Commonwealth of Massachusetts
Group Insurance Commission

P.O. Box 8747 • BOSTON, MA 02114-8747
(617) 727-2310 www.mass.gov/gic

Insurance Enrollment and Change Form (FORM -1)

01 ☐

Insured's GIC-ID (usually Soc. Sec. #)	Sex: Male ☐ Female ☐	Date of Birth	Dept. ID # or Agency/Division #
___ ___		/ /	/

Name - Last | First | MI

Address ☐ This is a new address | City | State | Zip Code

Date Entered Service	Bargaining Unit/Union Name	HR/CMS or UMASS Employee ID #:	Home Phone	Work Phone
/ /			( )	( )

02 ☐ **LIFE, HEALTH AND LTD COVERAGE** — **Effective Date: / 01 /**

New Enrollment ☐ Change ☐ **CANCEL COVERAGE** ☐ Long Term Disability (LTD) ☐ Health Insurance ☐ Optional Life Insurance

☐ **Basic Life Only**
☐ **Long Term Disability (LTD)**
☐ **Basic Life and Health** (Select one of the Health Plans below)

Annual Salary: $ _____

Salary Effective Date: _____ /_____ /_____

Health Plan

☐ **Commonwealth Indemnity Plan Basic** CIC: ☐Yes ☐ No
☐ **Commonwealth Indemnity Plan Community Choice** ☐ **Harvard Pilgrim Independence Plan** ☐ **Navigator by Tufts Health Plan** ☐ **Individual**
☐ **Commonwealth Indemnity Plan PLUS** ☐ **HMO:** _____ ☐ **Family**
(write in the name of the HMO)

Optional Life

Please Check One:

☐ **Automatic Increase**
Indicate Multiple Factor (1-8): _____
Multiple Factor 2-8 times is allowed only with Automatic increase.
Changing from Non Automatic to Automatic requires a medical form.

☐ **Non Automatic Increase**
Amount $: _____
No more than $1000 less than annual salary rounded down to the nearest $ 1,000

Please Check One:

☐ **Smoker**

☐ **Non-Smoker**
Yes, I have been tobacco free for the past 12 months and choose the lower optional life insurance rates

03 ☐ **Name Change** | Previous Name | New Name

LEAVE OF ABSENCE

FOR GIC USE ONLY: **Effective Date: / 01 /**

04 ☐ **Leave Is:** ☐ With Pay ☐ Without Pay — Leave Pay Status: ☐ Part ☐ Full

Leave Type (You MUST Check one of the following):

____ Educational ____ Family (for dep > age 3) *____ Maternity *____ Personal Illness ____ Sabbatical ____ FMLA
____ Family (for dep < age 3) *____ Industrial Accident ____ Military ____ Personal Reason ____ Suspension ____ Other

* Industrial Accident (without pay), Maternity (without pay), and Personal Illness (without pay) leaves all require the employee to submit a Form 11 to the Group Insurance Commission with a letter from the agency head approving the leave of absence.

Duration of Leave: Start Date / / End Date / / Last Day on Payroll / /

05 ☐ **Return to Payroll Deduction:** First Day Back on Payroll / /

INSURED CHANGES

FOR GIC USE ONLY: **Effective Date: / 01 /**

06 ☐ **Retirement** Date Retired / /

07 ☐ **Transfer to another Agency** Name of Agency Transferred to — Effective Date / /

08 ☐ **Transfer from another Agency** Previous Agency — Effective Date / /

09 ☐ **Termination Coverage (if elected)** Termination Reason _____ Termination Date _____ /_____ /_____

☐ 39 -Week Layoff Coverage ☐ Deferred Retiree ☐ COBRA (must complete COBRA application) ☐ Conversion (contact carrier for application)

SIGNATURE REQUIRED

Long Term Disability Insurance (LTD)
I understand that by not applying to be insured for Long Term Disability (LTD) insurance when first eligible, I may not apply for LTD Insurance until I have provided satisfactory medical evidence of insurability.

Optional Life Insurance
I understand that by not applying to be insured for Optional Life Insurance when first eligible, I may not apply for or increase my Optional Life Insurance until I have provided satisfactory medical evidence of insurability.

Deduction Authorization
I authorize my employer, or direct my pension authority , to deduct from my payroll or pension check the amount required for the coverage I have selected.

At Retirement
I hereby certify that I have filed, or intend to file, an application for retirement and desire to continue my present coverage as a retiree. I also understand that if I am Medicare eligible, I am required to join one of the Group Insurance Commission's Medicare supplemental health plans to continue health coverage.

Termination
I understand that by electing to continue coverage under COBRA or Conversion, I must complete and return the corresponding application in order for this coverage to go into effect.

• If you are applying for Health Insurance, be sure to file a Form IDF to list family members • If you are enrolling in an HMO, be sure to file an application with the Plan.

x _____ Signature of Applicant Date

x _____ Signature of Authorized Official Date

FOR GIC USE ONLY:	Entered	Verified	Political Subdivision

Commonwealth of Massachusetts
Group Insurance Commission

Your Benefits Connection

Employee Acknowledgement Form

You are responsible for familiarizing yourself with your benefit options:

- Basic Life Insurance
- Basic Life & Health Insurance
- Optional Life Insurance
- Long Term Disability (LTD)
- Dental/Vision *(if eligible)*
- Health Care Spending Acount (HCSA)
- Dependent Care Assistance Program (DCAP)

Your signature is required on this form before your agency can process your benefit elections. Please sign, date and return this form to your GIC Coordinator after you have reviewed the *Benefit Decision Guide*. (Or for visually impaired employees, have listened to the BDG audiotape.)

I hereby acknowledge that I have reviewed the most recent *GIC Benefit Decision Guide* before I made my benefit elections.

Name: _____

(Please print)

Signature: _____

Social Security Number: _____

Date: _____

Employee: Return this signed form to your GIC Coordinator with your benefit elections.
GIC Coordinator: Retain original signed form in employee's personnel file.

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(617) 727-2310 www.mass.gov/gic

INSURANCE DATA FORM (IDF)

PLEASE PRINT CLEARLY

This form is required for new enrollments in any Group Insurance Commission family health plan and for any changes in spouse or dependents. Complete it and any other health plan forms provided by your Group Insurance Coordinator and return them to the Coordinator. If you are a retiree, please return the form to the GIC. Please PRINT clearly. Incomplete forms will be returned.

CHECK ONE: ☐ **NEW MEMBER** ☐ **ADDITION** ☐ **DELETION** ☐ **CORRECTION**

Important: You are required to provide a copy of a marriage certificate, birth certificate, separation agreement, divorce decree, certificate of appointment as legal guardian, etc., for each person you list as a dependent. Failure to provide this documentation will result in your spouse/dependent not being covered. If you are deleting a spouse or dependent under age 19, you must provide proof of other coverage.

INSURED INFORMATION

1) Social Security Number _____ 2) Date of Birth _____ (Month Day Year) 3) Sex ☐ M ☐ F

4) Name _____ (Last First Middle)

5) Address _____ (Street)

_____ (City State Zip Code)

6) Are you enrolled in Medicare? ☐ Yes ☐ No If yes, Medicare claim # _____

7) Health Plan (Check one) ☐ Commonwealth Indemnity Plan Basic ☐ Commonwealth Indemnity Plan Community Choice ☐ Commonwealth Indemnity Plan PLUS
☐ Navigator By Tufts Health Plan ☐ Harvard Pilgrim Independence Plan ☐ HMO Name: _____

SPOUSE/DEPENDENT INFORMATION

List below all family members, including your spouse, who will be covered under your family plan. Please provide all Social Security Numbers and **exact** dates of birth for each dependent. Coverage for all children ends at age 19, except for full-time students and handicapped dependents whose applications have been approved by the Group Insurance Commission. Married children are not eligible. You are required to complete a student or handicapped application for any dependent you are listing below who is age 19 or over. Attach separate sheet if additional space is required.

Last Name	First	Middle	Relationship	Date of Birth	Sex	Social Security Number

Reason for addition or deletion: _____ Effective date: _____

SPOUSE INFORMATION

Is your spouse employed? ☐ Yes ☐ No Name of employer _____ Address of employer _____

Is your spouse covered under his or her employer's group health insurance plan? ☐ Yes ☐ No Name of insurance company _____

Policy/Certificate Number _____ Address of insurance company _____

Are you and/or your children covered under your spouse's group health insurance plan? You: ☐ Yes ☐ No Children: ☐ Yes ☐ No

Is your spouse enrolled in Medicare? ☐ Yes ☐ No If yes, Medicare claim number _____

FORMER SPOUSE

Name _____ (Last First Middle) Social Security Number _____ Date of Birth _____ Date of Divorce _____

Address _____ (Street City State Zip Code)

Is your former spouse employed? ☐ Yes ☐ No Name of employer _____

Is your former spouse covered under his or her employer's group health insurance plan? ☐ Yes ☐ No

IMPORTANT: YOU MUST SIGN BELOW

Signed under the pains and penalties of perjury, I certify that the information I have provided is, to the best of my knowledge, complete and accurate.

Signature _____ Date _____

ACTIVE EMPLOYEES: RETURN COMPLETED FORM TO YOUR GIC COORDINATOR. **RETIREES**: RETURN COMPLETED FORM TO THE GIC

Form IDF 3/06 10,000

FOR GIC COORDINATOR USE ONLY **Dept. ID # or Agency/Division #** _____

Name of GIC Coordinator _____ Agency Telephone Number _____

Agency Name _____

Agency Address _____

FOR GIC USE ONLY

Entered _____

Verified _____

Date _____

LIFE INSURANCE BENEFICIARY DESIGNATION FORM

Commonwealth of Massachusetts
Group Insurance Commission

Insured GIC-ID:	Agency/Division
– –	/

Insured Name: First	M.I.	Last

Street Address

City	State	Zip Code

YOU MUST READ INSTRUCTIONS ON BACK BEFORE COMPLETING FORM – PRINT CLEARLY IN CAPITAL LETTERS

BENEFICIARY #1

First Name	M.I.	Last Name ❑ Same as Insured	RELATIONSHIP
			❑ Spouse ❑ Parent ❑ Child ❑ Brother/Sister ❑ Other, specify:

Street Address ❑ Same as Insured

City	State	Zip Code	Country *(if not U.S.A.)*	% OF PROCEEDS (Do Not Put $ Amount)

BENEFICIARY #2

First Name	M.I.	Last Name ❑ Same as Insured	RELATIONSHIP
			❑ Spouse ❑ Parent ❑ Child ❑ Brother/Sister ❑ Other, specify:

Street Address ❑ Same as Insured

City	State	Zip Code	Country *(if not U.S.A.)*	% OF PROCEEDS (Do Not Put $ Amount)

BENEFICIARY #3

First Name	M.I.	Last Name ❑ Same as Insured	RELATIONSHIP
			❑ Spouse ❑ Parent ❑ Child ❑ Brother/Sister ❑ Other, specify:

Street Address ❑ Same as Insured

City	State	Zip Code	Country *(if not U.S.A.)*	% OF PROCEEDS (Do Not Put $ Amount)

I hereby make the above designation of beneficiary revoking any and all previous beneficiary nominations and make the above nomination of beneficiary with respect to all insurance provided now or at any time in the future under the group insurance policy(ies). I still reserve the privilege of making other and future changes subject to the policy provisions.

If more than one beneficiary is designated, settlement will be made in equal shares to such of the designated beneficiary(ies) as survive me, unless otherwise provided herein. If no designated beneficiary(ies) survive me, settlement will be made as provided in the policy in the following order; to the spouse, then to the children, then to the parents, then to the siblings, then to the estate.

_____ _____

Signature of Insured Date

PLEASE MAKE A COPY OF THIS COMPLETED FORM AND FILE WITH YOUR IMPORTANT RECORDS AND PAPERS.

FOR GIC USE ONLY

Please return to address shown on reverse side.

Commonwealth of Massachusetts ■ Group Insurance Commission
P.O. Box 8747 ■ Boston, MA 02114-8747

PLEASE READ ALL INSTRUCTIONS AND EXAMPLES CAREFULLY BEFORE COMPLETING THIS FORM.

INSTRUCTIONS

1. Please print all beneficiary information clearly in capital letters on the lines provided, indicating your beneficiary's name, relationship, address and the percentage of proceeds to be paid to each beneficiary. Incomplete forms will be returned. Refer to the samples illustrated to the right to assist you in the completion of your form.

2. If you do not provide a percentage of proceeds for your beneficiaries, the proceeds will be divided equally among all listed beneficiaries. If you provide a percentage for some but not all of the listed beneficiaries, your form will be returned to you to complete. **DO NOT PUT A DOLLAR AMOUNT IN THE *"% of Proceeds"* BOX.**

3. Use this form to designate up to three beneficiaries. If you wish to list more than three beneficiaries, **DO NOT** use this form. Instead, you must obtain a Nomination of Beneficiary form (G-500) from the GIC Coordinator at your worksite and use that form to list all your beneficiaries. If you are a retiree and need a G-500, please call (617) 727-2310 Ext. 1.

4. If you list beneficiaries who have the same last name as you, **DO NOT** write their last name. Instead, simply mark an ***"X"*** in the *"Same as Insured"* box for each beneficiary who has the same last name as yours.

5. If you list beneficiaries who live at the same address as you, **DO NOT** write in their address. Instead, simply mark an ***"X"*** in the *"Same as Insured"* box for each beneficiary who lives at your address.

6. Please sign and date the form clearly, in ink, where indicated. Keep a copy of the completed form with your important papers.

7. Please return this completed form to the Group Insurance Commission.

BENEFICIARY #1 — RELATIONSHIP: [X] Spouse [ ] Parent [ ] Child [ ] Brother/Sister [ ] Other, specify:
First Name: JOHN | M.I.: Q | Last Name: SMITH | [ ] Same as Insured
Street Address: 100 YOUR STREET RD | [ ] Same as Insured
City: YOURTOWN | State: MA | Zip Code: 01234 | Country *(if not U.S.A.)* | % of Proceeds*: 100%

BENEFICIARY #2 — RELATIONSHIP: [ ] Spouse [ ] Parent [ ] Child [ ] Brother/Sister [ ] Other, specify:
First Name | M.I. | Last Name | [ ] Same as Insured
Street Address | [ ] Same as Insured
City | State | Zip Code | Country *(if not U.S.A.)* | % of Proceeds*

BENEFICIARY #3 — RELATIONSHIP: [ ] Spouse [ ] Parent [ ] Child [ ] Brother/Sister [ ] Other, specify:
First Name | M.I. | Last Name | [ ] Same as Insured
Street Address | [ ] Same as Insured
City | State | Zip Code | Country *(if not U.S.A.)* | % of Proceeds*

BENEFICIARY #1 — RELATIONSHIP: [ ] Spouse [ ] Parent [X] Child [ ] Brother/Sister [ ] Other, specify:
First Name: BETH | M.I.: L | Last Name: JONES | [ ] Same as Insured
Street Address: 25 MAIN ST | [ ] Same as Insured
City: YOURTOWN | State: MA | Zip Code: 56789 | Country *(if not U.S.A.)* | % of Proceeds*: 50%

BENEFICIARY #2 — RELATIONSHIP: [ ] Spouse [ ] Parent [X] Child [ ] Brother/Sister [ ] Other, specify:
First Name: MATTHEW | M.I.: J | Last Name | [X] Same as Insured
Street Address: 42 CENTER AVE | [ ] Same as Insured
City: YOURTOWN | State: MA | Zip Code: 56789 | Country *(if not U.S.A.)* | % of Proceeds*: 50%

BENEFICIARY #3 — RELATIONSHIP: [ ] Spouse [ ] Parent [ ] Child [ ] Brother/Sister [ ] Other, specify:
First Name | M.I. | Last Name | [ ] Same as Insured
Street Address | [ ] Same as Insured
City | State | Zip Code | Country *(if not U.S.A.)* | % of Proceeds*

- If you list two or more beneficiaries with a specific percentage designated to each, proceeds will be paid as you designated. If one of the beneficiaries dies before you, proceeds will be paid to the remaining beneficiary(ies).
- If you list more than one beneficiary and indicate 100% for each one, this means that when you die, the first beneficiary will receive 100% of the proceeds. However, if the first beneficiary dies before you, the second designated beneficiary will receive 100% of the proceeds. If the second beneficiary also dies before you, your third beneficiary will receive 100% of the payment.
- If all designated beneficiaries die before you, payment will be made according to the terms of your life insurance policies in effect at the time of your death.

PLEASE COMPLETE FORM ON THE OTHER SIDE.

Commonwealth of Massachusetts
Group Insurance Commission
Your Benefits Connection

Commonwealth of Massachusetts
Group Insurance Commission

P. O. Box 8747
19 Staniford Street
Boston, Massachusetts 02114-8747
(617) 727-2310

NOMINATION OF BENEFICIARIES FORM G-500

For four or more beneficiaries and special designations (e.g. estate or trust)

Insured GIC ID - -	**Agency Name**	
Insured Name: First MI	**Last**	
Street Address		
City	**State**	**Zip Code**

I hereby make the following designation of beneficiary (ies), revoking any and all previous beneficiary nominations, and make the following nomination of beneficiary with respect to all insurance provided now or at any time in the future under the group insurance policy(ies). I still reserve the privilege of making other and future changes subject to the policy provisions.

If more than one beneficiary is designated, settlement will be made in equal shares to such of the designated beneficiary(ies) as survive me, unless otherwise provided herein. If no designated beneficiary(ies) survive me, settlement will be made as provided in the policy in the following order: to the spouse, then to the children, then to the parents, then to the siblings, then to the estate.

Please print below each beneficiary's name, address, relationship to you and percentage of proceeds. Be sure to sign and date the form. PLEASE PRINT CLEARLY.

Beneficiaries:

_____

_____

_____

_____

_____

_____

Signature of Insured: _____ **Date:**_____

Please make a copy of the completed form to keep with your important papers.

Commonwealth of Massachusetts
Group Insurance Commission

Your Benefits Connection

Commonwealth Indemnity Plan Statement of Verification for Student Coverage Application

Under the GIC's family plan, insurance coverage for a dependent ends the last day of the month in which he/she turns age 19. To ensure continuity of coverage, you must complete in full a "Statement of Verification for Student Coverage" prior to the dependent's 19th birthday. If you would like to apply for student coverage on behalf of your child, please complete the Statement of Verification for Student Coverage" for the family plan under which you have health insurance. If you are not enrolled in any health insurance plan through the GIC, but have the GIC Dental/Vision plan for managers, legislators, legislative staff and certain executive office staff, call the GIC at 1.617.727.2310 for the GIC Dental/Vision student form. Please keep in mind the following:

- Students who attend school less than full time are not eligible for student coverage.
- Student must attend an accredited educational institution.
- The insured must be enrolled in family plan coverage.
- The insured must fill out the top section of the form and forward it to the accredited educational institution to complete section two and return it to the address listed on the form.

Important Information

Upon receipt of your application, UNICARE, the administrator of the Commonwealth Indemnity Plan, will determine student coverage eligibility and effective dates. Once this application has been approved, the Plan will contact you every six months to reverify the full-time student status of your dependent student. If you do not respond to these requests for reverification, your student-dependent's coverage will be terminated.

It is your responsibility to notify either the Group Insurance Commission or UNICARE when your student dependent is no longer a full-time student, withdraws from school, is put on a medical leave of absence from school, gets married, or graduates. Health insurance coverage for your student-dependent (age 19 and over) ends at the end of the month in which your child ceases to be a full-time student. Student coverage for a dependent on a school-approved medical leave of absence ends on the last day of the semester in which he or she last attended class, at which time he or she may apply for Dependent COBRA coverage. Your dependent's options to continue coverage if any of these events occur will be provided to you with every student reverification you receive from your health plan. You may also receive information concerning these options by calling UNICARE's Commonwealth Service Center at 1.800.442.9300.

The Plan can only accept original applications, not photocopies or fax transmittals.

We suggest you keep a copy of this application for your records.

For additional information about student coverage, see the GIC's website: www.mass.gov/gic

3/06

Commonwealth of Massachusetts
Group Insurance Commission

Commonwealth Indemnity Plan
STATEMENT OF
VERIFICATION - STUDENT COVERAGE

I. (COMPLETED BY INSURED)

PLEASE PRINT AND ANSWER ALL QUESTIONS, forwarding this to the accredited educational institution to complete the second section and return to the Commonwealth Service Center. Be sure to refer to important information on page one of this application.

Name of Insured_____ Insured's Social Security #_____

Address_____ Telephone Number (_____)_____

_____

Place of Employment_____

Name of Student_____ Student's Social Security #_____

Relationship to Insured_____ Student's Date of Birth ___/___/___

Name of Accredited Educational Institution Student is Attending_____

Address of School_____

City, State, Zip_____

Has your dependent's education been interrupted for more than 24 months from his/her 19th birthday? Yes___ No____

I understand that I must notify UNICARE's Commonwealth Service Center when my dependent is no longer a full-time student, withdraws from school, is put on a medical leave of absence from school or graduates; and I understand that my health plan may, at times, certify with the educational institution my dependent is attending that he/she is enrolled full-time. I have read the important information section on page one of this form.

Signature of Insured_____ Date_____

II. EDUCATION CERTIFICATE
(COMPLETED BY INSTITUTION)

The above student has been accepted or is currently enrolled in our educational institution.

Date Admitted:_____ Expected date of graduation: Month_____Year_____

a. Full-time_____ If full-time has he/she been considered full-time since admission? ___ yes ____no
If no, other than for a medical leave, when was he/she not considered full-time? _____

b. Part-time_____ c. Minimum full-time credit hours_____

d. Is the student on a medical leave of absence? Yes_____ No_____ If yes, leave approved From____ To_____

_____ _____
Name of Accredited Educational Institution Name of Registrar

PLEASE AFFIX SCHOOL SEAL

_____ _____
Date Signature of Registrar or Designee

Return application to:
UNICARE, Commonwealth Service Center
PO Box 9016
Andover, MA 01810-0916

III. FOR PLAN USE ONLY

Approved_____ Effective Date___/___/___ Expiration Date ___/__/___

Denied_____ Reason_____

Reviewed by _____ Date__/__/__

3/06

Commonwealth of Massachusetts
Group Insurance Commission

Your Benefits Connection

Navigator by Tufts Health Plan Statement of Verification for Student Coverage Application

Under the GIC's family plan, insurance coverage for a dependent ends the last day of the month in which he/she turns age 19. To ensure continuity of coverage, you must complete in full a "Statement of Verification For Student Coverage" prior to the dependent's 19th birthday. If you are interested in applying for student coverage, complete the Statement of Verification for Student Coverage" for the family plan under which you have health insurance. If you are not enrolled in any health insurance plan through the GIC, but have the GIC Dental/Vision plan for managers, legislators, legislative staff and certain executive office staff, call the GIC at (617) 727-2310 for the GIC Dental/Vision student form. Please keep in mind the following:

- Students who attend school less than full time are not eligible for student coverage.
- Student must attend an accredited educational institution.
- The insured must be enrolled in family plan coverage.
- The insured must fill out the top section of the form and forward it to the accredited educational institution to complete section two and return it to the address listed on the form.

Important Information

Upon receipt of your application, Tufts Health Plan, the administrator of the Navigator Plan, will determine student coverage eligibility and effective dates. Once this application has been approved, the Plan will contact you every six months to reverify the full-time student status of your dependent student. If you do not respond to these requests for reverification, your student-dependent's coverage will be terminated.

It is your responsibility to notify either the Group Insurance Commission or Tufts Health Plan when your student dependent is no longer a full-time student, withdraws from school, is put on a medical leave of absence from school, gets married, or graduates. Health insurance coverage for your student-dependent (age 19 and over) ends at the end of the month in which your child ceases to be a full-time student. Student coverage for a dependent on a school-approved medical leave of absence ends on the last day of the semester in which he or she last attended class, at which time he or she may apply for Dependent COBRA coverage. Your dependent's options to continue coverage if any of these events occur will be provided to you with every student reverification you receive from your health plan. You may also receive information concerning these options by calling Tufts Health Plan at 1.800.870.9488.

The Plan can only accept original applications, not photocopies or fax transmittals.

We suggest you keep a copy of this application for your records.

For additional information about student coverage, see our website www.mass.gov/gic

3/06

Commonwealth of Massachusetts
Group Insurance Commission

NAVIGATOR BY TUFTS HEALTH PLAN
STATEMENT OF VERIFICATION - STUDENT COVERAGE

I. (COMPLETED BY INSURED)

PLEASE PRINT AND ANSWER ALL QUESTIONS, forwarding this to the accredited educational institution to complete the second section and return to the Tufts Health Plan. Be sure to refer to important information on page one of this application.

Name of Insured_____ Insured's Social Security #_____

Address_____ Telephone Number (_____)_____

_____

Place of Employment_____

Name of Student_____ Student's Social Security #_____

Relationship to Insured_____ Student's Date of Birth ___/___/___

Name of Accredited Educational Institution Student is Attending_____

Address of School_____

City, State, Zip_____

Has your dependent's education been interrupted for more than 24 months from his/her 19th birthday? Yes___ No____

I understand that I must notify the Tufts Health Plan when my dependent is no longer a full-time student, withdraws from school, is put on a medical leave of absence from school or graduates; and I understand that my health plan may, at times, certify with the educational institution my dependent is attending that he/she is enrolled full-time. I have read the important information section on page one of this form.

Signature of Insured_____ Date_____

II. EDUCATION CERTIFICATE (COMPLETED BY INSTITUTION)

The above student has been accepted or is currently enrolled in our educational institution.

Date Admitted:_____ Expected date of graduation: Month_____Year_____

a. Full-time_____ If full-time has he/she been considered full-time since admission? ___ yes ____no
If no, other than for a medical leave, when was he/she not considered full-time? _____

b. Part-time_____ c. Minimum full-time credit hours_____

d. Is the student on a medical leave of absence? Yes_____ No_____ If yes, leave approved From____ To_____

_____ _____
Name of Accredited Educational Institution Name of Registrar

PLEASE AFFIX SCHOOL SEAL

_____ _____
Date Signature of Registrar or Designee

Return application to:
Tufts Health Plan, Attn: Commonwealth of MA Enrollment
705 Mount Auburn Street, PO Box 9186
Watertown, MA 02471-9186

III. FOR PLAN USE ONLY

Approved_____ Effective Date___/___/___ Expiration Date ___/__/___

Denied_____ Reason_____

Reviewed by _____ Date__/__/__

Commonwealth of Massachusetts
Group Insurance Commission

Your Benefits Connection

Harvard Pilgrim Independence Plan
Statement of Verification for Student Coverage Application

Under the GIC's family plan, insurance coverage for a dependent ends the last day of the month in which he/she turns age 19. To ensure continuity of coverage, you must complete in full a "Statement of Verification For Student Coverage" prior to the dependent's 19th birthday. If you are interested in applying for student coverage, complete the Statement of Verification for Student Coverage" for the family plan under which you have health insurance. If you are not enrolled in any health insurance plan through the GIC, but have the GIC Dental/Vision plan for managers, Legislators, Legislative staff and certain Executive Office staff, call the GIC at (617) 727-2310 for the GIC Dental/Vision student form. Please keep in mind the following:

- Students who attend school less than full time are not eligible for student coverage.
- Student must attend an accredited educational institution.
- The insured must be enrolled in family plan coverage.
- The insured must fill out the top section of the form and forward it to the accredited educational institution to complete section two and return it to the address listed on the form.

Important Information

Upon receipt of your application, Harvard Pilgrim Health Care will determine student coverage eligibility and effective dates. Once this application has been approved, the Plan will contact you every six months to reverify the full-time student status of your dependent student. If you do not respond to these requests for reverification, your student-dependent's coverage will be terminated.

It is your responsibility to notify either the Group Insurance Commission or Harvard Pilgrim Health Care when your student dependent is no longer a full-time student, withdraws from school, is put on a medical leave of absence from school, gets married, or graduates. Health insurance coverage for your student-dependent (age 19 and over) ends at the end of the month in which your child ceases to be a full-time student. Student coverage for a dependent on a school-approved medical leave of absence ends on the last day of the semester in which he or she last attended class, at which time he or she may apply for Dependent COBRA coverage. Your dependent's options to continue coverage if any of these events occur will be provided to you with every student reverification you receive from your health plan. You may also receive information concerning these options by calling Harvard Pilgrim Health Care at 1.800.542.1499.

We can only accept original applications, not photocopies or fax transmittals.

We suggest you keep a copy of this application for your records.

For additional information about student coverage, see the GIC's website www.mass.gov/gic

3/2006

Commonwealth of Massachusetts
Group Insurance Commission

HARVARD PILGRIM STATEMENT OF VERIFICATION - STUDENT COVERAGE

I. (COMPLETED BY INSURED)

PLEASE PRINT AND ANSWER ALL QUESTIONS, forwarding this to the accredited educational institution to complete the second section and return to Harvard Pilgrim Health Care. Be sure to refer to important information on page one of this application.

Name of Insured_____ Insured's Social Security #_____

Address_____ Telephone Number (_____)_____

_____

Place of Employment_____

Name of Student_____ Student's Social Security #_____

Relationship to Insured_____ Student's Date of Birth ___/___/___

Name of Accredited Educational Institution Student is Attending_____

Address of School_____

City, State, Zip_____

Has your dependent's education been interrupted for more than 24 months from his/her 19th birthday? Yes___ No____

I understand that I must notify Harvard Pilgrim Health Care when my dependent is no longer a full-time student, withdraws from school, is put on a medical leave of absence from school or graduates; and I understand that my health plan may, at times, certify with the educational institution my dependent is attending that he/she is enrolled full-time. I have read the important information section on page one of this form.

Signature of Insured_____ Date_____

II. EDUCATION CERTIFICATE (COMPLETED BY INSTITUTION)

The above student has been accepted or is currently enrolled in our educational institution.

Date Admitted:_____ Expected date of graduation: Month_____Year_____

a. Full-time_____ If full-time has he/she been considered full-time since admission? ___ yes ____no
If no, other than for a medical leave, when was he/she not considered full-time? _____

b. Part-time_____ c. Minimum full-time credit hours_____

d. Is the student on a medical leave of absence? Yes_____ No_____ If yes, leave approved From____ To_____

_____ _____
Name of Accredited Educational Institution Name of Registrar

PLEASE AFFIX SCHOOL SEAL

_____ _____
Date Signature of Registrar or Designee

Return application to:
Harvard Pilgrim Health Care, Account Services GIC Student Coordinator
P.O. Box 9185
Quincy, MA 02269

III. FOR PLAN USE ONLY

Approved_____ Effective Date___/___/___ Expiration Date ___/__/___

Denied_____ Reason_____

Reviewed by _____ Date__/__/__

Commonwealth of Massachusetts
Group Insurance Commission

Your Benefits Connection

HMO Statement of Verification for Student Coverage Application

Under the GIC's family plan, insurance coverage for a dependent ends the last day of the month in which he/she turns age 19. To ensure continuity of coverage, you must complete in full a "Statement of Verification for Student Coverage" prior to the dependent's 19th birthday. If you would like to apply for student coverage on behalf of your child, please complete the Statement of Verification for Student Coverage" for the family plan under which you have health insurance. If you are not enrolled in any health insurance plan through the GIC, but have the GIC Dental/Vision plan for managers, legislators, legislative staff and certain executive office staff, call the GIC at (617) 727-2310 for the GIC Dental/Vision student form. Please keep in mind the following:

- Students who attend school less than full time are not eligible for student coverage.
- Student must attend an accredited educational institution.
- The insured must be enrolled in family plan coverage.
- The insured must fill out the top section of the form and forward it to the accredited educational institution to complete section two and return it to the address listed on the form.

Important Information

Upon receipt of your application, the Group Insurance Commission will determine student coverage eligibility and effective dates. Once this application has been approved by the GIC, your HMO will contact you every spring and every fall thereafter to reverify the full-time student status of your dependent student. If you do not respond to these requests for reverification, your student-dependent's coverage will be terminated.

It is your responsibility to notify the Group Insurance Commission when your student dependent is no longer a full-time student, withdraws from school, is put on a medical leave of absence from school, gets married, or graduates. Health insurance coverage for your student-dependent (age 19 and over) ends at the end of the month in which your child ceases to be a full-time student. Student coverage for a dependent on a school-approved medical leave of absence ends on the last day of the semester in which he or she last attended class, at which time he or she may apply for Dependent COBRA coverage. Your dependent's options to continue coverage if any of these events occur will be provided to you with every student reverification you receive from the Group Insurance Commission. You may also receive information concerning these options by calling the Group Insurance Commission at (617) 727-2310.

We can only accept original applications, not photocopies or fax transmittals.

We suggest you keep a copy of this application for your records.

For additional information about student coverage, see our website: www.mass.gov/gic

3/06

Commonwealth of Massachusetts
Group Insurance Commission

HMO STATEMENT OF VERIFICATION - STUDENT COVERAGE

I. (COMPLETED BY INSURED)

PLEASE PRINT AND ANSWER ALL QUESTIONS, forwarding this to the accredited educational institution to complete the second section and return to the GIC. Be sure to refer to important information on page one of this application.

Name of Insured_____ Insured's Social Security #_____

Address_____ Telephone Number (_____)_____

_____

Place of Employment_____

Name of Student_____ Student's Social Security #_____

Relationship to Insured_____ Student's Date of Birth ___/___/___

Name of Accredited Educational Institution Student is Attending_____

Address of School_____

City, State, Zip_____

Has your dependent's education been interrupted for more than 24 months from his/her 19th birthday? Yes___ No____

I understand that I must notify the GIC when my dependent is no longer a full-time student, withdraws from school, is put on a medical leave of absence from school or graduates; and I understand that my health plan may, at times, certify with the educational institution my dependent is attending that he/she is enrolled full-time. I have read the important information section on page one of this form.

Signature of Insured_____ Date_____

II. EDUCATION CERTIFICATE (COMPLETED BY INSTITUTION)

The above student has been accepted or is currently enrolled in our educational institution.

Date Admitted:_____ Expected date of graduation: Month_____Year_____

a. Full-time_____ If full-time has he/she been considered full-time since admission? ___ yes ____no
If no, other than for a medical leave, when was he/she not considered full-time? _____

b. Part-time_____ c. Minimum full-time credit hours_____

d. Is the student on a medical leave of absence? Yes_____ No_____ If yes, leave approved From____ To_____

_____ _____
Name of Accredited Educational Institution Name of Registrar

PLEASE AFFIX SCHOOL SEAL

_____ _____
Date Signature of Registrar or Designee

Return application to:
Group Insurance Commission, PO Box 8747, Boston, MA 02114-8747

III. FOR GIC USE ONLY

Insured Parent's Coverage_____ Effective Date ___/___/___ Agency/Division_____/_____

Status

Approved_____ Effective Date___/___/___Expiration Date ___/__/___

Denied_____ Reason_____

Reviewed by _____ Date__/__/__

Commonwealth of Massachusetts
Group Insurance Commission
Your Benefits Connection

COMMONWEALTH OF MASSACHUSETTS
GROUP INSURANCE COMMISSION

PRE-TAX BASIC LIFE & HEALTH INSURANCE PLAN

The Commonwealth has adopted the State Pre-Tax Basic Life & Health Insurance Plan to save you money on your insurance premiums. Under this Plan, if you have basic life or basic life and health insurance through the Group Insurance Commission, your premiums will be deducted from your salary on a pre-tax basis. This means that you will not have to pay state or federal income taxes on your share of the cost of basic life and health insurance premiums, which will result in a slightly larger paycheck. This will not affect your current insurance benefits; coverage will remain the same.

This benefit is automatic, no further action on your part is required to receive this benefit.

Federal law, however, requires that you be offered the opportunity to decline this benefit. If you elect not to participate in this plan you may not change your mind until an annual enrollment period, or unless or until one of the following occurs:

1. you get married or divorced;
2. the birth or adoption of a child;
3. your spouse or dependent dies;
4. your spouse commences or is terminated from employment;
5. you or your spouse take an unpaid leave of absence;
6. you involuntarily lose health insurance through no fault of your own.

If you decide not to participate in this plan you must complete the other side of this Election Not to Participate Form and submit it to your GIC or Payroll Coordinator. If you do not submit a completed form, your insurance premiums will be deducted on a pre-tax basis automatically.

Commonwealth of Massachusetts
Group Insurance Commission

COMMONWEALTH OF MASSACHUSETTS

GROUP INSURANCE COMMISSION

Pre-tax Basic Life & Health Insurance Plan
Election Not to Participate Form

YOU MUST READ PAGE ONE BEFORE COMPLETING FORM - PRINT CLEARLY IN CAPITAL LETTERS

Social Security Number		**Agency/Division**	
Insured Name:	**First**	**M.I.**	**Last**
Street Address			
City		**State**	**Zip Code**
Signature of Insured			**Date**

I hereby elect NOT to participate in the state Pre-Tax Basic Life & Health Insurance Plan. I understand that by making this election I have chosen to have my share of basic life and basic health insurance premiums paid on an after-tax basis. I understand that as a result of this election not to participate in the plan, I will not receive an increase in “take home pay.”

I further understand that I may not change this election until an annual enrollment period or unless one of the following “change in family status” occurs:

1. I get married or divorced;
2. A child is born to me, or I adopt one;
3. My spouse or one of my dependents dies;
4. My spouse commences or is terminated from employment;
5. I or my spouse take an unpaid leave of absence; or
6. I involuntarily lose my health insurance coverage through no fault of my own.

3/06

TO: INSURED EMPLOYEES ON APPROVED LEAVE OF ABSENCE DUE TO PERSONAL ILLNESS/INJURY (INCLUDING CLAIMS FOR INDUSTRIAL ACCIDENT)

FROM: The Group Insurance Commission

RE: Application to Continue Part Cost Premiums

This Application for Reduction of Monthly Premium (Form 11) is required for all insured employees who are on approved leave of absence due to:

- Maternity
- Personal illness
- Workers Compensation/Industrial Accident

Approval of this application by the GIC will entitle you to continue part cost premiums for your group insurance coverage; this is the premium that is normally deducted from your salary.

While you are on this approved leave of absence your monthly group insurance premiums are usually not payroll deducted and you are required to remit payment directly to the GIC.

If the leave of absence is NOT approved by the Agency Head, you will be billed at the full cost premium.

THE FOLLOWING FOUR ITEMS MUST BE RETURNED TOGETHER. INCOMPLETE APPLICATIONS WILL NOT BE PROCESSED.

1. Page one: Completed by you, the employee
2. Page two: Completed by you and the Agency Head
3. Page three: Completed by your physician
4. Letter approving Leave of Absence: Completed by your Agency Head

SECTION ONE (To Be Completed by Employee)

Name		GIC ID NO. (usually Social Security no.)	
Street Address	City	State	Zip
Date of Birth		Home Telephone No. ( ) —	
Place of Employment		Occupation	
Last Day of Work		Expected Date of Return to Work	
Nature of Illness or Injury			

I hereby certify under the pains and penalties of perjury that I am not entitled to receive any salary, wages or other compensation from my employer and my absence is due to my own illness, or injury, and NOT the illness or injury of another person. I understand that this application shall not create an insurable interest or otherwise reinstate coverage which has been terminated. I also understand that any leave which is granted to me will be subject to periodic review by the Group Insurance Commission.

Signature of Employee _____ Date_____

SECTION TWO (To Be Completed by Agency Head/Employee)

AGENCY MUST ENCLOSE A COPY OF LETTER GRANTING LEAVE OF ABSENCE TO EMPLOYEE

1. Is this employee on Approved Leave of Absence due to Illness or Injury? Yes ☐ No ☐

If yes, reason: Illness ☐ Injury ☐ Maternity ☐ Worker's Compensation/Industrial Accident ☐

Duration of Leave From: _____ To: _____
PROVIDE SPECIFIC DATES ONLY Month/Day/Year Month/Day/Year

2. Balance of: Vac. Days ☐ Pers. Days ☐ Sick Days ☐ Comp. Days ☐

3. Last Day Employee on Payroll _____

4. Does the employee hold a Civil Service position? Yes ☐ No ☐ Does Not Apply to Agency ☐

If yes or does not apply to agency, continue to number 5.

If no, please complete the following:

It is hereby agreed that _____ will be reappointed to his/her current
(print name of employee)

position of _____, if it is available, or to a similar position to which he/she is entitled upon return from his/her medical leave of absence.

_____ _____
Signature of Agency Head/Department Head Date

I hereby agree to return to work in my current position, or a similar position, or to a position to which I am otherwise entitled at the conclusion of such leave of absence.

_____ _____
Signature of Employee Date

5. Briefly describe the Employee's job duties:

6. Please complete the following information:

Name of Agency Head _____ Title _____

Telephone Number ( ) _____

_____ _____
Signature of Agency Head/Department Head Date

SECTION THREE (To Be Completed by Physician)

(Please attach additional sheets if necessary)

1. Name of Patient:
2. Patient's Diagnosis and date of onset of illness:
3. How long have you been treating this patient for this diagnosis?
4. Describe your treatment plan and prognosis for this patient in as much detail as possible:
5. Can the patient return to work at this time? Yes ☐ No ☐

   If no, when do you think the patient will be able to return to work?
6. Please indicate any alterations in the work requirements that would enable the patient to return to work earlier. (Please explain in detail):

I hereby certify that I have examined the above named patient and certify under the pains and penalties of perjury that the information listed above is true, based upon my knowledge and belief.

Signature of Physician _____ Date _____

Please print the following information:

Name of Physician

Street Address City State Zip

Telephone Number ( )

Specialty

Registration Number

SECTION FOUR (FOR GIC USE ONLY)

VALIDATION INFORMATION

Employee's Coverage _____ Effective Date _____

Agency _____ Division _____

APPROVAL/DISAPPROVAL INFORMATION

☐ Approval From _____ To _____

☐ Disapproval reason _____

Reviewed by _____ _____
GIC Supervisor Date

COMMENTS